Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DEO K BHATI MD
P O BOX 741865
DALLAS TX 75374

Carrier's Austin Representative Box
Box Number 15

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Date Received
March 8, 2011

MFDR Tracking Number
M4-11-2272-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAM…CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS…THE CURRENT RULES ALLOW REIMBURSEMENT…AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $525.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier issued check no. 100389721 on February 24, 2011 in the amount of $700.00. Please see attached print screen with the payment information. Since the payment amount is greater than the amount requested by the provider, then the **carrier requests reimbursement for any overpayment**…"

Response Submitted by: Flahive Ogden & Latson, P. O. Box 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2010	99456-WP-W5 95851	$500.00 $25.17	$500.00 $0.00
TOTAL		$525.17	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. Copies of the explanation of benefits were not submitted by either party for review. The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines.

Issues

1. Is the dispute eligible for review under 28 Texas Administrative Code §134.307?
2. Has the reported medical fee dispute been resolved/paid?
3. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
4. Is CPT code 95851 included in the MMI/IR examination?
5. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. 28 Texas Administrative Code §134.307(c)(2)(B) states, "Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division…The provider shall complete the required sections of the request in the form and manner prescribed by the division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include…a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute, or if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the submitted documentation the Division finds that the requestor did submit convincing evidence to support carrier receipt of "Request for Reconsideration" in accordance with Rule 133.307(e)(2)(B). The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines.
2. The respondent's response to the reported medical fee dispute states, "The carrier issued check no. 100389721 on February 24, 2011 in the amount of $700.00. Please see attached print screen with the payment information." Review of the submitted documentation, the Division finds that check number 100389721 issued on February 24, 2011 in the amount of $700.00 was for a Functional Capacity Evaluation which is not in dispute. Therefore, the disputed services will be reviewed per the applicable Division rules and fee guidelines.
3. The requestor billed the amount of $500.00 for CPT code 99456-WP-W5 with 1 (one) unit in Box 24G of the CMS-1500 for a Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00.

   To determine reimbursement for an IR, the method of calculating IR and the number of body area/conditions are reviewed. Review of the narrative documentation submitted supports the rating of the lumbar spine (spine) using the Diagnosis Related Estimates (DRE) method per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition in accordance with 28 Texas Administrative Code §134.204(j)(4)(C)(i)(I). Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I) the Maximum Allowable Reimbursement (MAR) for the Impairment Rating is $150.00.

   The combined Maximum Allowable Reimbursement (MAR) for the disputed CPT code 99456-WP-W5 is $500.00.
4. The provider also billed the amount of $45.00 for CPT code 95851 with 1 (one) unit in Box 24G of the CMS-1500 for Range of Motion (ROM) testing for the MMI/IR examination. There was no reimbursement for the CPT code 95851 by the respondent. 28 Texas Administrative Code §134.204(j) states in pertinent part, "Reimbursement for the MMI/IR exam includes the following components: The medical examination; consultation with injured worker; Review of medical records and films; Reports (DWC Form-069), including the initial narrative report as well as any subsequent reports in response to the need for clarification, explanation, or reconsideration; Calculations, tables, figures, and worksheets; and Tests used to assign an IR, as outlined in the AMA's *Guides to the Evaluation of Permanent Impairment* (AMA Guides) [as stated in the Act and Chapter 130 rules]." Therefore, in accordance with 28 Texas Administrative Code §134.204(j), CPT Code 95851, Range of Motion (ROM) testing, is included in the reimbursement for the MMI/IR exam and is not separately payable. No additional amount for CPT code 95851 can be recommended.
5. The respondent has previously reimbursed the amount of $0.00 for the disputed CPT code 99456-WP-W5. Therefore, the requestor is entitled to reimbursement of $500.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 6, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.